Kansas Coalition
against sexual & domestic violence

634 SW Harrison
Topeka, KS 66603
785-232-9784
FAX 785-266-1874

coalition@kcsdv.org
facebook.com/KCSDV
kcsdv.org

Senate Committee on Public Health and Welfare

Neutral SB 497

March 16, 2016

Chairman O'Donnell and members of the committee,

The Kansas Coalition Against Sexual and Domestic Violence (KCSDV) is a statewide non-profit organization whose membership is comprised of the 29 sexual and domestic violence programs serving survivors of domestic violence and sexual assault across the state.

SB 497 requires a physician or other healthcare professional to provide a routine opt-out screening for certain birth risk factors: tobacco use, alcohol consumption or substance abuse, depression, or domestic violence. While KCSDV supports the recognition of the important safety considerations around domestic violence and pregnancy, domestic violence screening is very different than the screening for the other risk factors included in this bill. Depression and substance use and abuse are conditions and risks of which treatment is already based in the medical field. Domestic violence, while a public safety concern whose effects can lead to health risks, is committed by a person other than the victim. Because the safety issues around domestic violence are directly linked to the behaviors of a third party, not the patient or the healthcare professional, screening for domestic violence requires a different approach than the others mentioned in SB 497.

If and when screening for domestic violence does take place in a medical setting, we must make sure that such screening focuses on the safety of the victim, confidentiality of the information, and making good referrals and access to resources when a patient discloses being a victim of domestic violence. First, domestic violence screening should be implemented in such a way to focus on the safety of the victim. This includes considering possible unintended consequences of the manner in which a domestic violence screening is done. For instance, will the screening be done one-on-one with the patient? A person accompanying a patient to a medical appointment could be the perpetrator of domestic violence or someone who may disclose the patient's answers to the perpetrator. This could either lead the patient to lie about their situation in order to protect their safety or could put the patient at an increased risk of danger after the screening.

Second, domestic violence screening should be done only with the informed consent of the patient. Informed consent must include the patient knowing what information is being gathered by the screening and what that information could be used for, who can access the information gathered, and whom can that information be shared with. What possible places might this information end up in the patient's records that could end up in the hands of the perpetrator of domestic violence? What access might the perpetrator have to the patient's medical records? Will the screening show up in health insurance records? Before requiring domestic violence screenings, these concerns need to be addressed. Only after understanding where this information may go, can a patient really give informed consent for these screenings or choose to opt-out.

Finally, how will healthcare professionals respond to the disclosure that their patient is a victim of domestic violence? SB 497's only guidance is that "[w]hen the physician or other healthcare professional determines that a pregnant woman has a birth risk factor, or is at high risk of a birth risk factor during the woman's pregnancy, the physician or other healthcare professional shall administer a repeat screening during the third trimester of pregnancy or as soon after labor and delivery as practicable." Healthcare professionals are in a unique position to reach victims of domestic violence, but without addressing how to respond to these disclosures, these professionals may not be equipped with the proper tools and resources to provide the patient with the most effective response. A well-meaning healthcare professional could tell the patient that they should leave the perpetrator or to go get a protection order. For every victim of domestic violence, however, safety looks different. Planning for the safety and individualized needs of each victim of domestic violence can be done by other professionals, such as domestic and sexual violence victim advocates, who are trained specifically to work with and support victims of domestic violence in a holistic and ongoing manner. Because of this, domestic violence screening should also include training for healthcare professionals on responding to disclosures and making good referrals to local community services dedicated to addressing the physical, emotional, and economic dangers affecting the safety of victims of domestic violence. Kansas does not yet have a coordinated, funded training effort for health care professionals. At this point, only sexual assault nurse examiners regularly have training offered through the Statewide SANE/SART Training and Coordination Project. More resources would have to be devoted to this effort in order to assure that well-intended screening for domestic violence would not lead to more danger and higher lethality rates in Kansas

For these reasons and because of the uncertainty of SB 497 as to the safety, confidentiality, and training when screening for domestic violence, KCSDV is neutral to SB 497. KCSDV would be willing and able to provide guidance and education regarding SB 497, as requested.

Submitted by,

Joyce Grover, Esq.
Executive Director

Jessica Nasternak, J.D, M.S.
Director of Legal and Policy